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Stories in MEDNEWS use these abbreviations after a Navy medical professional's name to show affiliation: MC - Medical Corps (doctors); DC - Dental Corps; NC - Nurse Corps; MSC - Medical Service Corps (Navy researchers and administrative managers). Corpsmen and Dental Technician designators are identified in front of their names.

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Headline: Leaders unfold plan to modify, strengthen TRICARE
By Douglas J. Gillert, American Forces Press Service

WASHINGTON -- Defense health officials unfolded bold new ideas for making sure TRICARE works as planned to deliver quality health care in peace and war. The result could mean more care in-house and less from contractors.

Addressing the 1999 TRICARE conference here, DoD health chief Dr. Sue Bailey and others laid out a plan to address shortcomings in the managed health care plan. In the past six months, a group of Army and Air Force colonels and Navy captains has put together a scheme to re-engineer TRICARE administration.

CAPT Donald Arthur, MC, assistant chief of health care operations for the Navy Bureau of Medicine in Washington, D.C., and a member of the re-engineering team, said the effort represents a complete "change of culture." He presented the plan Feb. 1 to several hundred TRICARE

providers and administrators gathered here from around the world to discuss ways to fine-tune the health plan.

The tri-service group's model ties staffing at military hospitals and clinics to their readiness mission. The facilities must have sufficient staffing to meet wartime requirements, he said, but they also must be augmented by available resources -- presumably a mix of civilian contract and military providers -- to meet peacetime requirements.

TRICARE was set up with the idea of complementing military resources with civilian contractors, so the plan doesn't seem like such a big change. But Bailey, assistant secretary of defense for health affairs, pointed out military resources are sometimes underused when DoD relies too much on contractors. She said that's going to change, beginning with the mostly contracted appointment system.

"I've initiated a review of the ratio of direct-care [in-house] phone awareness vs. contract," Bailey said. "I don't think we need to contract as much out." She said plans to shift functions back to the military is part of a larger effort to keep the promise and to restore members' trust in military medicine.

Bailey said the military has always provided quality health care to battlefields but hasn't been as faithful toward families. She said there are inexorable links between wartime and peacetime medicine, including a well-trained medical team, a healthier, prevention-oriented beneficiary population and good information management.

"We are the HMO that goes to war," Bailey said. "We need our bills paid, our phones answered and our appointments made." She said TRICARE's success depends greatly on improving the overall health of beneficiaries, of tracking their health through better recordkeeping, and through responding to patient concerns and perceptions.

"Perception is reality. We need to simplify the message, make our system user-friendly and keep congressional leaders informed of the link between peacetime and wartime health care," she said. And one old perception of military medicine she doesn't want TRICARE to repeat is that it's "better than nothing."

"I want military medicine to be better than everything," Bailey said.

TRICARE Management Activity Director James Sears said the re-engineering plan will enable TRICARE to reach its full potential. He said the necessity for change is absolute.

"There are many threats to dismantle TRICARE," Sears said. He said TRICARE administrators must figure out how to move military medicine "from sick call to managed care to a healthy population." Sears challenged the medics to build a more effective organization.

"We have it in our grasp," he said, "to make TRICARE work."

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Headline: DoD seeks funds for seniors' health care

commitment
By Douglas J. Gillert, American Forces Press Service

WASHINGTON -- The Defense Department wants to make sure all people eligible for health benefits get the care they need, including those over age 65, a senior health official said here Feb. 2.

Speaking at the 1999 TRICARE Conference, Mary Gerwin said DoD is committed to providing health care to all eligible retired service members and their families, but it has to find a way to fund the care. She said the group represents the fastest growing segment of the DoD beneficiary population, and DoD is looking at several options for their health care.

"The number of retirees is growing disproportionately to active duty," said Gerwin, a senior adviser to DoD health chief Dr. Sue Bailey and former staff director of the Senate Committee on Aging. She said there are 1.3 million military retirees over age 65 today and the number will rise to 1.6 million by 2005. Since 1994, over-65 retirees have increased 5 percent, while the active duty population has decreased 12 percent, she said. Retirees over 65 represent "more than 50 percent of Military Health System beneficiaries," she said.

Federal statutes prohibit staffing military hospitals to treat patients 65 and older, who also are eligible for Medicare benefits. Military treatment facilities can only provide over-65s with space-available health care. Even as the over-65 population is rising, however, space-available care has been shrinking due to base closures and reduced clinic and hospital capacity.

Compounding cost issues, most retirees living close to military facilities depend on space-available care and don't have separate health insurance, Gerwin said. "They benefit from the free prescription drugs, even when they don't use the military treatment facility for their primary care," she said. Medicare doesn't cover outpatient drugs.

The department currently is looking at several ways to deliver care to its elderly population. These include a three-year demonstration of Medicare Subvention in six geographical locations; Medicare will reimburse participating military hospitals that enroll over-65 patients in TRICARE Senior Prime.

About 22,000 seniors enrolled to take part in the test. "We will be able to use Medicare reimbursement to leverage and expand care we deliver to over-65s," Gerwin said. However, she said, some seniors may not want to enroll because the demonstration will last just three years. If DoD doesn't adopt the plan, retirees would have to pay higher premiums to rejoin Medicare Plan B.

Retirees also can enroll in Medicare health maintenance organizations rather than risk losing temporary military health benefits, she said. DoD has matched the benefits offered by Medicare HMOs. "Once we get them in, we're hooked for all their Medicare-based care," Gerwin said. "We

have to be able to deliver these benefits" -- home care, for example.
DoD recently announced a second demonstration at eight sites. Up to 66,000 over-65 retirees and eligible family members will be allowed to enroll in the Federal Employees Health Benefits Plan. The Office of Personnel Management will negotiate with the plans and carriers, and enrollees will receive information this summer, Gerwin said.
Two other demonstrations beginning Jan. 1, 2000, will begin supplemental TRICARE coverage at two sites and will expand pharmacy benefits to retirees over 65 in selected areas, including use of a national mail order pharmacy.
Each of these programs comes at a cost, Gerwin said, with the FEHBP option being the most expensive at $1.4 billion to $1.6 billion a year. Estimated annual costs are up to $300 million for the pharmacy plan and $600 million for the TRICARE supplement, she said. The figures are based on estimates of participation rates and a cost analysis provided by CNA Corp., which has done other studies of DoD health care programs.
Gerwin said she doesn't think DoD can expect more money from Congress, but it would, instead, need "a major pull down in our system" to pay for something as costly as the federal employees plan. She said the costs of the pharmacy benefit could mean larger co-pays for name-brand drugs and higher charges to other beneficiaries. "Or Congress could just put us in the OPM budget."

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Headline: Cost, access, quality shape TRICARE success in Northwest
By Douglas J. Gillert, American Forces Press Service

WASHINGTON -- Reports from DoD's oldest TRICARE region show a high level of success in controlling costs, improving access and maintaining quality.
A survey of more than 10,000 DoD health care beneficiaries in TRICARE Region 11 -- Washington, Oregon and part of Idaho --measured the delivery of health care to some 340,000 beneficiaries between 1994 and 1998. TRICARE began in the area in 1993. Dr. James Sears, TRICARE Management Activity executive director, called the survey "all good news."
"In a time when there's significant inflation in health care costs, they found no increase in cost to the government or beneficiaries," Sears said. At the same time, the survey reported that Region 11 medical providers maintained high quality standards. "There's even a plus-up in perception [among survey respondents] of quality," he said.
In terms of access, improvements were noted in several categories, Sears said. "They're getting their primary care when they need it, they're getting preventive services they need and they aren't using the ER as much. Not having to go to the emergency room to get their primary urgent or acute care is a sign of a healthy system."

Sears said he's particularly pleased with Region 11 beneficiaries' increased reliance on preventive health services.

"That's a major goal we're after -- to keep people healthy so they don't have to use health care services as much," he said.

CNA Corp. and the Institute for Defense Analyses conducted the Region 11 survey and will perform similar surveys in all regions over a four-year period, Sears said. Congress mandated the study, which looks at "before" and "after" data to determine TRICARE's impact on military health care. Although the survey measured just one region, Sears said it reflects what he expects to find in every region.

"It's the same program we have put in place across the country," he said. "As the survey reaches all the other regions over the next two years, we anticipate similar results. There's no reason to think this program would be any less successful in other regions."

Next on tap for the survey this spring are Regions 3 (Southeast), 4 (Gulf South), 6 (Southwest), 9 (Southern California), 10 (Golden Gate) and 12 (Pacific), and a second look at Region 11. Regions 7 and 8 (Central) will be surveyed in 2000 and Regions 1 (Northeast), 2 (Mid-Atlantic) and 5 (Heartland) will follow in 2001.

Outcomes from the Region 11 survey "are in the direction we want them to be," Sears said. "But we've got a lot of feelers out to learn how the program is doing. This study is just one of them."

Annual and monthly customer surveys help Sears and his staff learn about and solve problems in the TRICARE system. "Most of the changes we're making, where we're placing new or additional emphasis, are based on feedback we're getting from these multiple channels," he said. "We're using this information to improve the current structure and future contracts."

What this and other surveys tell Sears is that TRICARE is doing well where it has matured, in Southern California, for example.

"We just have no negative noise level of any significance from the places where TRICARE has been in place and operating for awhile," he said.

In Southeast, Gulf South and some other newer regions, problems that existed a year ago have been corrected, he said. "We had problems with claims, networks and appointments. As of today, however, their networks are developed, they're paying claims and their telephone issues are history."

Sears said the same types of "hiccups" occur in every regional startup, and a similar maturing process eventually smoothes out the wrinkles. The Central region matured rapidly, he said, and he expects the Northeast, Mid-Atlantic and Heartland regions to improve quickly.

TRICARE has met with similar success overseas, an area

perceived to be a medical care trouble spot in the early 1990s, according to Air Force Maj. Brian Hurley, senior health analyst for military health systems operations at TRICARE. Surveys, he said, detected few claims turnaround problems and found high patient satisfaction with health care access and quality.

But surveys aren't the only tool DoD's using to gauge the health of health care. TRICARE management discusses health care issues regularly with the Military Coalition, a 5-million-member group of 26 military support associations, and the 3-million-member Military/Veterans Alliance. Sears has conducted meetings with the services' senior enlisted representatives to uncover and fix health care problems of enlisted members and their families. And Rudy de Leon, undersecretary of defense for personnel and readiness, has started conducting regional town hall meetings with medics and patients.

TRICARE is accomplishing all it was designed to do, but that doesn't mean it can't be improved, Sears said. "We want to continue showing improvement in every area, keeping costs down and ensuring every beneficiary, whether active duty or retired or family member, has quick access to quality care."

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Headline: Reserve leadership gets anthrax vaccinations

By Jim Garamone, American Forces Press Service

WASHINGTON -- The Reserve component chiefs led by example Jan. 25 by receiving the first in a six-shot series of anthrax vaccinations here during a ceremony at the Reserve Officers Association midwinter conference.

Charles Cragin, acting assistant secretary of defense for reserve affairs, and 12 other reserve component leaders set the example for 900,000 reserve component members who will receive the shots by 2003.

"Since childhood we are accustomed to receiving vaccinations," Cragin said. "From smallpox to polio, we vaccinate to protect against diseases." The vaccination can protect service members against anthrax, a livestock disease that kills 99 out of 100 unprotected people.

"[Anthrax] is the No. 1 weapon of choice in biological warfare. It is effective and easy to weaponize. If inhaled, it is almost always deadly."

Cragin said giving service members anthrax vaccinations is a prudent form of force protection. Some reserve component service members have already started receiving the shots. Reservists deploying or already deployed to Southwest Asia or Korea, high-risk areas for biological warfare, have started receiving the vaccinations. He assured the audience of the safety of the vaccine, noting no long-term side effects have surfaced since the Food and Drug Administration approved it 29 years ago. DoD has inoculated about 170,000 personnel with more than 475,000 separate shots. Dr. [Lt. Gen.] Ron Blanck, Army surgeon general,

said side effects have been minimal.

"In about 5 percent of those vaccinated, there has been a little redness and soreness where the shot was given," he said. "It's a killed bacteria serum. So problems that you would associate with a live serum are not possible."

Blanck, who has had the shots, said the program has gone remarkably smoothly with no reports of major problems associated with the serum. One case of Guillain-Barre syndrome was reported, but the service member made a complete recovery and medical officials do not know if the vaccination caused the illness.

Cragin said he had "utmost confidence" in the safety and effectiveness of the vaccine. Blanck said he spends an "awful lot of time" assuring service members and their families that the vaccinations are safe. The FDA approved the vaccine, he said, and the Army ran supplemental tests on it. Also, DoD developed a tracking system that shows who received shots, where, and what batch of vaccine was used to inoculate them. Finally, the whole process undergoes inspection by an outside expert.

Service members who refuse the shots are disobeying a direct order, said Cragin, and they are putting their colleagues in jeopardy. "If they deploy and they are in an area where this weapon is used, now their colleagues have to worry about them," he said.

Inhaled anthrax causes pneumonia-like symptoms one to six days after exposure. Victims eventually drown, in essence, when their lungs fill with fluids. The six-shot series provides full protection from the disease. Getting a partial series provides only partial protection; however, even after three shots service members obtain 80 percent to 85 percent immunity, Blanck said.

Because reserve component personnel are spread over a large area and get together for only a weekend each month, DoD will change the medical protocol for their shots. For active duty and deploying reservists the protocol works like this: The first three shots are given in two-week intervals. The following three shots are administered at 6, 12, and 18 months. The program also includes an annual booster.

The following reserve leaders received their shots during the ceremony. Charles L. Cragin, acting assistant secretary of defense for reserve affairs; Mark Davidson, deputy assistant secretary of the Navy for manpower and reserve affairs; Bryan E. Sharratt, deputy assistant secretary of the Air Force for reserve affairs; Maj. Gen. Thomas J. Plewes, chief, Army Reserve; Maj. Gen. Roger C. Schultz, director, Army National Guard; and Maj. Gen. James E. Sherrard III, chief, Air Force Reserve.

Others receiving the shots were: Brig. Gen. James Helmly, deputy chief, Army Reserve; Brig. Gen. Michael J. Squier, deputy director, Army National Guard; RADM John B. Totushek, director, Naval Reserve; RADM John F. Brunelli, commander, Naval Surface Reserve Force; RADM Thomas J. Barrett, director for Reserve and Training, U.S. Coast Guard

Headquarters; Col. Howard Schick, deputy director for Reserve Affairs, U.S. Marine Corps; and CAPT James Willis, deputy director for Reserve and Training, U.S. Coast Guard Headquarters.

Other officers participated in the ceremony but had already started the inoculation process. They were: Air Force Lt. Gen. Russell C. Davis, chief, National Guard Bureau; Air Force Maj. Gen. Robert A. Mcintosh, assistant to the chairman of the Joint Chiefs of Staff; and Brig. Gen. Craig B. McKinley, deputy director, Air National Guard.

Cragin said service members can find out more about the vaccination program visiting the anthrax web site at http://www.defenselink.mil/specials/Anthrax

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Headline: Doc makes high altitude delivery

By Earl W. Hicks, Bureau of Medicine and Surgery

WASHINGTON -- CAPT John Smith, MC, was flying at approximately 30,000 feet, when he realized his flight was carrying a special delivery package about to require an untimely opening.

When Smith, Commanding Officer of U.S. Naval Hospital Yokosuka, Japan, boarded his plane in Japan, heading for the annual TRICARE conference in Washington, D.C., he wanted what most flyers pray for – an uneventful trip to his destination. But about two hours from John F. Kennedy airport, high over the wilds of Canada, he realized that he wouldn't be having a routine flight.

"Is there a doctor onboard the plane?" came the urgent call from the plane's speakers, pulling Smith from a sound sleep. Again there was an urgent request for a doctor. Smith, a family practice specialist in Navy Medicine responded to the stewardess' request for help.

"I identified myself to the stewardess and she told me a woman onboard the plane was having a baby," he said.

This news didn't cause Smith to panic. As a family practitioner he had delivered hundreds of babies. But to do so in an airplane loaded with a couple of hundred passengers would make the effort a little tricky. And there was definitely a shortage of baby delivery tools and medical supplies onboard. Worries about the woman or the baby having problems were concerns Smith didn't want to think about.

"Both stewardesses helped me get the woman to the back of the plane, near the galley and the heads where we had room to examine my new patient," Smith said. "It was clear she would deliver at any time."

What could have complicated the process even more was the woman being Chinese and not speaking English. Fortunately one of the stewardesses and the woman's traveling companion did, so the instructions from Smith to the woman were clear.

The plane's first aid kits became Smith's medical tools during the delivery. After the lucky traveler produced a

robust baby girl, Smith used tourniquet material from the kits to tie off the umbilical cord. He said that he later learned the baby girl weighed five pounds, six ounces.

Mother and baby were plucked from the plane at the airport and at last report they were doing fine.

A successful delivery was actually the second piece of good news that day for Smith. Before leaving for his trip, he learned that his hospital had achieved "Accreditation with Commendation" from the Joint Commission for Accreditation of Healthcare Organizations. It seemed appropriate that the busiest services at his hospital are family practice and obstetrics.

But for this Navy Medicine leader, the airborne birth was just another day of doing business.

"It was all just part of being a physician," Smith said. "My Navy training proved to be very valuable. I was happy to come forward when the stewardesses needed me."

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Headline: Y2K database aids in contingency plan development
By Dan Barber, Naval Hospital Twentynine Palms

TWENTYNINE PALMS, Calif. -- Once again, a Naval medical facility is showing its customers that their care center will not be unprepared for the year 2000 arrival. Naval Hospital Twentynine Palms is one of the Navy hospitals preparing for the Year 2000 change by developing a "Y2K" contingency plan that uses a locally designed database. According to CDR William Mock, NC, head of Naval Hospital Twentynine Palms' Management Information Department and designer of the hospital's Y2K database, Navy Medicine is concerned with Y2K compliance in facilities based issues; bio-medical equipment and information management or information technology.

Working with a close deadline, Mock reviewed Navy guidance about writing a Y2K contingency plan and went to work. He developed a database that standardized contingency plans and continuity of operations plans.

"I realized that I couldn't write contingency plans for everything that was out there that could potentially fail," he said. "I realized that I needed help from the subject matter experts that use these systems and equipment, so I wrote a database and placed it on one of the hospital's main computer servers, with the front end on the users computers." With that distribution, Mock said the users of applications contributed to the command's Y2K contingency plan.

According to him, by placing the data base on the server and making it available on the network allowed the hospital's department heads to review the contingency plans and add their input, which allowed completion of the contingency plan in a short time.

Mock has shared this database with all other Y2K Action Officers in the Bureau of Medicine and Surgery. Deputy Surgeon General of the Navy, RADM Todd Fisher, liked the

program and made it available on the BUMED web site for other medical facilities. The web address is http://support1.med.navy.mil/bumed/y2k/y2k_guidance.htm

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Headline: Pensacola training set preps medical team for field service

By Rod Duren, Naval Hospital Pensacola

PENSACOLA, Fla. -- Training to supply medical support in a combat or operations-other-than-war environment has become more real for the medical team at Naval Hospital Pensacola, Fla. The hospital recently opened its Fleet Hospital training set.

"It was amazing how everyone came together to put this Fleet Hospital training set into operation," said Hospitalman Newton Holsapple. "I think it will be a great deal of help to everyone in case we have to take it into a combat zone or on a humanitarian mission. After some training, we should be better able to react to our field working environments."

RADM Rod Melendez, DC, Assistant Chief for Education, Training and Personnel for the Bureau of Medicine and Surgery, was in Pensacola to officially unveil the Tent City on its first day of training.

The admiral complimented Fleet Hospital Pensacola staff in getting the training set operational and training underway, while maintaining the quality of care at the Naval Hospital Pensacola.

"Your reputation from previous training at Camp Pendleton, as a hard-working and efficient team, precedes you," he said. You've learned your lessons very well, and I am confident you will set new standards of excellence during your Operational Readiness Evaluation next fall."

Historically, Fleet Hospital personnel received limited training opportunities in their operational billet. These Deployable Medical Platforms (DEPMEDS) training sets will enable Fleet Hospital personnel to train more effectively in their own backyard, according to LT Howard Aupke, MSC, head of Fleet Hospital operations. He said the training set will provide the opportunity for personnel to become familiar with equipment and supplies normally found in a deployed Fleet Hospital.

Naval Hospital Pensacola is one of six Navy military treatment facilities whose operational platform is designed to provide direct support as a combat zone Fleet Hospital. The other five are Naval Hospitals at Bremerton, Wash., Camp Pendleton, Calif., Camp Lejeune, N.C., Jacksonville, Fla., and Portsmouth, Va.

"This Fleet Hospital training continues to be a very rewarding experience," said Hospital Corpsman Third Class Frances Diaz, assigned to the endoscopy department, where examinations of internal organs are performed. "By taking part in this training we're developing that field-like atmosphere and we're learning the intricacies of the Fleet

Hospital equipment, which could have a direct affect on patient care in a real-time situation," she said.

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Headline: Medical aid to Sri Lanka improves surgeons skills
By Judith A. Robertson, Naval Hospital Bremerton

BREMERTON, Wash. -- A Navy orthopaedic surgeon from Naval Hospital Bremerton led the first joint service medical team to Sri Lanka as part of the month-long Blast Resuscitation and Victim Assistance or BRAVA program in late 1998. Six military medical professionals from the Navy, Army and Air Force, augmented by two force protection personnel, comprised the first team. The second military medical team will depart early April.

"This was an outstanding opportunity to gain exposure to patients who have sustained war injuries," said CAPT Dana Covey, MC, who led the eight-person team. "It provided the opportunity to learn from the Sri Lankans who have extensive experience in treating these patients and to impart some of our knowledge to their medical personnel."

Covey, who is the Director of Surgical Services at Naval Hospital Bremerton, said the precept of BRAVA is to conduct education and training in acute surgical management of landmine and blast injuries.

According to Covey, this project was the brainchild of CDR John Olsen, MC. Olsen. Olsen, who is assigned to the Office of the Secretary of Defense for Strategy and Requirements, Office of Humanitarian Assistance, has published numerous papers about medical readiness training for future conflicts.

"We have the opportunity to provide care to those who are impoverished and under cared for and also enhance our ability as military physicians by working in third world countries, which are traditionally resource limited and training our people in the care of landmine and other explosive device injuries before the event occurs," he said.

The small, island nation, formerly Ceylon, lies like a teardrop off the tip of India in the Bay of Bengal. The country has been torn by civil war between government forces and the separatist Tamils, causing 55,000 deaths and tens of thousands wounded. Many have died because of exploding ordnance.

The BRAVA medical team, consisting of two orthopaedic surgeons, a general surgeon, an operating room technician, an anesthetist and a physical therapist worked at the 2800-bed National Hospital in Colombo.

"It is the largest medical center in Sri Lanka and it treats both military and civilian patients who sustain war wounds," Covey said. "Just before the team arrived, heavy fighting had occurred near a couple of the towns and many of the patients were admitted to National Hospital. The hospital had over three thousand inpatients at any given time. Some had to be put on the floor and supplies and

equipment were in short supply."
According to Covey, Operation BRAVA directly addresses the need to increase the readiness of military medical personnel to treat combat casualties.
"It is very important to continue and build upon the groundwork laid during the first BRAVA mission," said Covery. "The Navy will continue to provide personnel to future joint service BRAVA teams."

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Headline: Double twins cause double vision at Corps School
By LT Youssef H. Aboul-Enein, Medical Service Corps, and LTJG Jacqueline Rosas, Medical Service Corps, Naval Hospital Great Lakes

GREAT LAKES, Ill. -- People at the Naval Hospital Corps School are rubbing their eyes in bewilderment these days. Sailing through school's halls are two sets of identical twins, who will soon become Navy Corpsmen.
Jennifer and Jayme Lindgren and Josie and Jessie Peralta are setting a first by being the first documented double set of twins are going together through the 88-year old Corps School. The Lindgren's are from Helena, Mont., and were born two minutes apart 19 years ago. Jennifer is the oldest, but it was Jayme who got her twin sister to join the Navy.
"I have a goal of becoming a nurse mid-wife which requires a Registered Nurse degree followed by specialized training. I thought being a Corpsman would give me the experience and opportunity to realize this dream," said Jayme.
Jennifer, who initially wanted to go into the Lithographer rating, did not want to separate from her sister and joined Jayme in striking for Corpsman.
"Some outside people do not notice we are twins; but since joining the military, the uniform makes us stick out," said Jennifer. When discussing their civilian lives, Jennifer said there were other discriminators for the twins. "I wore blue and Jayme [wore] more pink. I did not paint my fingernails and Jayme did."

In Corps School, the twins are study partners, with Jayme keeping Jennifer in line. However, when it comes to laboratory work, both twins are fully capable.

Jose and Jessie Peralta are two more 19 year-old, identical twins going through the school. But these youngsters are not completely unfamiliar with the Navy. Their father retired as a Chief Petty Officer after 24 years of service. Jose was the first to sign-up with the recruiter in Norfolk, Virginia. The recruiter encouraged him to bring along his twin brother and convinced him to sign up.

Jose said he wants to become a physical therapist. Just as Jayme Lindgren did, Jose decided becoming a corpsman would help him reach his goal. Jessie is the younger brother with only 9 minutes between the two.

“We studied together throughout school,” said Jesse. “But he was more advanced in math,” added Jose.

So, to you all who may be using Navy medical facilities, don’t panic. You are not seeing double if you spot the twins helping with your care.

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Headline: Food is not a bitter pill in Navy hospitals
By Earl W. Hicks, Bureau of Medicine and Surgery

WASHINGTON -- Modern technology and well-trained medical care providers can make a hospital stay much shorter and more pleasant than in years past. But even with shortened stays and better medicine, patients still have the ages old complaint about poor quality hospital food.

Today, that complaint is disappearing for Navy hospital meals. Two organizations, Naval Medical Center San Diego, Calif., and Naval Hospital Jacksonville, Fla., are showing everyone how it can be done. They are the 1999 winners of the Captain Edward F. Ney, Memorial Awards for outstanding hospital food service. National Naval Medical Center Bethesda, Md., and Naval Hospital Charleston, S.C., were runners-up in the competition.

CAPT Ney was in the Supply Corps and led the Subsistence Division from 1940 - 45. He developed procedures for the problems associated with procuring food for the Navy. Formal presentation of the Ney Awards will be made in San Diego, Calif., March 12 during the International Food Service Executives Association (IFSEA) conference. Ney Awards are presented in afloat, ashore and hospital food service categories.

The Ney Awards were established in 1958 by the Secretary of the Navy and IFSEA to improve and recognize quality food service in the Navy. IFSEA is a food service industry trade association whose members include executive chefs, operators, dietitians, consultants, managers and owners of catering firms, restaurants, hotels and clubs.

The Ney Award recognizes food service excellence by evaluating areas of customer service such as food preparation, restaurant considerations, cleanliness and management.

Critical eyes checking Navy hospital food service is another plus of Navy Medicine. And it is not an overlooked concern for people such as Quartermaster First Class Karon Matthews, who had her baby at U.S. Naval Hospital Naples, Italy.

“The food is always on time, at the right temperature and tastes good,” she said. Matthews also said that in addition to receiving healthy meals, she appreciated the cheerful attitudes of food preparation personnel.

So, for patients whose days in the hospital could mean being poked and prodded by care providers, needle punctures and swallowing foul tasting medicine, mealtime can be something eagerly anticipated, not only for the nutritional value, but also simply for the pleasure of enjoying

delicious food. Navy hospitals are not letting their patients down.

According to LCDR Al Siewertsen, MSC, who is with the Navy Food Service Division at Naval Supply Systems Command, Mechanicsburg, Penn., and also one of the evaluators for the semi-finalists phase of competition, eleven hospitals participated in the semi-finalist stage. That is a strong commentary about the quality of food service throughout the Navy hospital system.

Providing a well-run food service is not just one way for the patients. Food service operations have incentives to ensure that their facilities produce tasty, nutritious food and operate well run food preparation areas. Hospital finalists in the Ney competition receive training quotas to send top performing Mess Management Specialists to a 10-day culinary training program at the Culinary Institute of America. First place food service operations send three representatives as guests of IFSEA to their annual conference.

Some veterans of other times, now defending their own health, believe the food service is helping in their fight. GySgt George Michel, USMC (ret.); MSgt Donald Niesen, USMC (ret.); and Sgt First Class Enrique Santana, USA (ret.), all being cared for at Naval Medical Center San Diego, enjoy their meal times.

According to these vets who have seen a military meal or two, Naval Medical Center San Diego has food preparation right: they get what they ordered –hot if it was supposed to be hot, cold if it was supposed to be cold. And they were of one voice when describing the most important food consideration for feeling well: the meals taste good.

LCDR Al Siewertsen, a Registered Dietitian who represents the Bureau of Medicine and Surgery at the Naval Supply Systems Command, contributed to this story.

Large hospital semifinalists
Naval Medical Center, San Diego - winner
National Naval Medical Center, Bethesda - runner-up
Naval Medical Center, Portsmouth

Small hospital semifinalists
Naval Hospital Jacksonville, Fla. - winner
Naval Hospital Charleston, S.C. - runner-up
Naval Hospital Guantanamo Bay, Cuba;
Naval Hospital Twentynine Palms, Calif.
Naval Hospital Camp Pendleton, Calif.
U.S. Naval Hospital Yokosuka, Japan
U.S. Naval Hospital Guam
U.S. Naval Hospital Naples, Italy

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Headline: TRICARE question and answer

Question: How does TRICARE improve military readiness?
Answer: TRICARE increases flexibility of the Military

Health System, which affords our military medical personnel the ability to maintain their personal readiness while assigned to a base hospital or clinic. This flexibility is demonstrated in the unprecedented collaboration among the military medical departments and in the partnerships we are building with civilian health care companies. These initiatives, which include joint service sharing and strong public-private partnerships, contribute to the durability of the Military Health System.

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Headline: Healthwatch: Avoid risk: one beat at a time
By Kimberly A. Rawlings, Bureau of Medicine and Surgery

WASHINGTON -- The heart is for caring and feeling, but very few people care for their heart.

The most vital organ in the human body - the heart - is just as susceptible to disease as any other organ.

Statistics show that a large number of Americans are not heeding the advice of their health care professionals to improve their lifestyles, exercise more, stop smoking and watch their diets. The American Heart Association reports that more than 2,600 Americans die each day of cardiovascular disease – an average of one death every 33 seconds.

To eliminate the possibility of becoming a statistic in the nation’s number one killer -- reduce the risk.

“Increased activity has a direct effect on making the heart stronger, which can help reduce or control other risk factors such as elevated cholesterol and high blood pressure,” said CDR Wayne McBride, Medical Corps, deputy director of preventive medicine and occupational health at the Bureau of Medicine and Surgery, Washington, D.C.

Lack of physical activity is no excuse for putting one’s self at risk for heart disease. Recent studies suggest that even walking and many household activities can have a positive effect on the heart.

“Physical fitness is free. It doesn’t cost anything to go out and walk or run. An exercise program is important to maintaining a healthy heart,” said CDR Robert Raspa, head of Family Practice at Naval Hospital Jacksonville.

In fact, inactive people double the risk of heart disease making them equal to people with high blood pressure, elevated cholesterol, or cigarette smokers, according to Dr. Valentin Fuster, director of the Cardiovascular Institute, Mount Sinai Medical Center in New York city.

If you are not an active person and fall into one of the risk categories, there are symptoms that indicate you may be experiencing a heart attack. They include heavy chest pain, nausea, light-headedness, and cold sweats.

“Chest pain that either radiates down the left arm or into the neck is a very serious sign,” said McBride. “When present, this suggests the need for immediate treatment and evaluation by a physician.”

Several tests are available to diagnose possible heart

disease. The test performed will depend on the patient's risk factors, history of heart problems, current symptoms and the physician's assessment.

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Comments about and ideas for MEDNEWS are welcome. Story submissions are encouraged. Contact MEDNEWS editor, Earl W. Hicks, at email: mednews@us.med.navy.mil; Telephone 202/762-3223, (DSN) 762-3223, or fax 202/762-3224.

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